STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 00 B. WING	01/27/2012

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ROSEGATE VILLAGE	7510 ROSEGATE DR INDIANAPOLIS, IN 46237

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00102153. Complaint IN00102153 - Unsubstantiated, due to lack of evidence. Survey dates: January 23, 24, 25, 26, 27, 2012 Facility number: 011149 Provider number: 155757 AIM number: 200829340 Survey Team: Courtney Mujic, RN - TC (January 23, 24, 25, 26, 2012) Barb Hughes, RN (January 24, 25, 26, 27, 2012) Karina Gates, Medical Surveyor Beth Walsh, RN Census Bed Type: SNF: 40 SNF/NF: 105 Total: 145 Census Payor Type: Medicare: 47 Medicaid: 78 Other: 20	F0000	Please accept this 2567 Plan of Correction for the Health Survey ending January 27, 2012 as the Provider's Letter of Credible Allegation. This Provider respectfully requests a Post Survey Revisit on or after February 26, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 145 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 2/02/12 by Suzanne Williams, RN			

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F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview, and record review, the facility failed to follow physician's orders for 2 of 4 residents (#106 and 96) reviewed for correct insulin administration and 2 of 11 residents (#143, #103) reviewed for diet orders, in a sample of 24. Findings include: 1. The clinical record for Resident #106 was reviewed on 1/27/12 at 10:00 a.m. The diagnosis for Resident #106 included, but was not limited to: diabetes mellitus. A recapitulation of the January 2012 Physician Orders, indicated Humalog (insulin treatment of blood sugar/glucose levels) was to be given per sliding scale of subsequent blood sugars (BS) from an Accucheck measurement. The sliding scale was BS 131-180=1 unit of Humalog, BS of 181-240= 2 units of Humalog, BS of 241-300=3 units of Humalog, BS of 301-350=4 units of Humalog, and 351-400=5 units of Humalog. Glucose greater than 400, give 6 units of Humalog and call MD (medical doctor).	F0282	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents #106 and #96 were immediately assessed to ensure blood sugars did not require further treatment. · Meal tickets for residents #143 and #103 have been updated to reflect current physician orders and both receive specialized diets. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents receiving sliding scale insulin have been identified and will be assessed for correct insulin administration. · All residents with specialized diet orders have been identified. Meal tickets for these residents have been audited to ensure services are being provided in accordance with each resident's written plan of care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents requiring insulin coverage per sliding scale will have the amount of insulin administered documented on the MAR and/or Capillary Blood Glucose Monitoring Tool by	02/26/2012

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	A review of the Capillary Blood Glucose Monitoring Tool indicated the resident's blood sugars (BS) were checked and in the range requiring Humalog insulin coverage per sliding scale. On the following dates and times the treatment area for the blood sugar was blank: 1/1/12 at 6:00 a.m., BS=224, 2 units of Humalog should have been administered 1/5/12 at 6:00 a.m., BS=157, 1 unit of Humalog should have been administered 1/7/12 at 6:00 a.m., BS=158, 1 unit of Humalog should have been administered 1/8/12 at 6:00 a.m., BS=175, 1 unit of Humalog should have been administered 1/9/12 at 6:00 a.m., BS=151, 1 unit of Humalog should have been administered 1/9/12 at 4:00 p.m., BS=217, 2 units of Humalog should have been administered 1/10/12 at 6:00 a.m., BS=160, 1 unit of Humalog should have been administered 1/13/12 at 6:00 a.m., BS=158, 1 unit of Humalog should have been administered 1/18/12 at 6:00 a.m., BS=276, 3 units of Humalog should have been administered 1/25/12 at 6:00 a.m., BS=161, 1 unit of Humalog should have been administered In an interview with the DoN (Director of Nursing), on 1/27/12 at 3:30 p.m., she indicated that she was unable to determine if the correct amount of insulin was given on the above dates.		licensed nurses. · An in-service will be completed by the Director of Nursing and/or designee on February 16, 2012 to licensed nurses on sliding scale insulin administration and documentation requirements. · The Director of Nursing Services and/or designee will assign a licensed nurse to review the MAR's of all residents receiving sliding scale insulin daily to ensure administration occurs per physician order. · An in-service will be completed by the Dietary Services Manager on February 23, 2012 to nursing, food service and therapy staff regarding facility processes for communicating and ensuring residents receive physician ordered specialized diets. · The Dietary Services Manager and/or designee will conduct tray audits every other day to ensure resident meals are prepared and served per physician order. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with documentation of insulin coverage per sliding scale. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · A CQI audit tool will be utilized by the Dietary Services Manager to monitor	

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	2. The clinical record for Resident #143 was reviewed on 1/25/12 at 4:10 p.m. The diagnoses for Resident #143 included, but were not limited to: diabetes mellitus, hypertension, depression, and dementia. A recapitulation of the January Physician's Orders indicated that Resident #143 had an order for a mechanical soft, consistent carbohydrate, thin liquids, and fruit and yogurt at all 3 meals. During an observation of Resident #143 eating dinner on 1/25/12 at 5:05 p.m., she was observed without a fruit plate and yogurt as part of her meal. During an observation of Resident #143 eating lunch on 1/26/12 at 11:38 a.m., she was observed without a fruit plate and yogurt as part of her meal. During an interview with the Dietary Manager on 1/26/12 at 1:15 p.m., she indicated that the kitchen staff probably forgot to put the fruit and yogurt on Resident #143's meal tray for the above dates. 3. The clinical record for Resident #103 was reviewed on 1/24/12 at 3:00 p.m.		compliance of residents receiving physician ordered specialized diets. Meal observations will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	The diagnoses for Resident #103 included, but were not limited to: dementia, hypertension, depression, and twisted colon. A recapitulation of the January Physician's Orders indicated that Resident #103 had an order for a regular diet and a fruit plate at meals. During an observation of Resident #103 eating dinner on 1/25/12 at 4:50 p.m., she was observed without a fruit plate as part of her meal. During an observation of Resident #103 eating lunch on 1/26/12 at 11:45 a.m., she was observed without a fruit plate as part of her meal. During an interview with the Dietary Manager on 1/26/12 at 1:15 p.m., she indicated that she did not know that Resident #103 had an order for a fruit plate at meals and the order was most likely overlooked. 4. The clinical record for Resident #96 was reviewed on 1/26/12 at 10:00 A.M. The diagnosis for Resident #96 included, but was not limited to, diabetes mellitus. Recapitulation of a physician order dated 12/1/11 indicated Novalog (insulin			

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	treatment of blood glucose levels) was to be given per sliding scale of blood sugars (BS) from an Accucheck measurement, and the results and sliding scale insulin amounts should be documented on the Diabetic Flow Sheet. The sliding scale for Novolog administration was BS 141-170=1 unit, 171-200 = 2 units, 201-230 = 3 units, 231-260= 4 units, 261-280= 5 units, 281-300=6 units, 301-350 7 units, 351-400 = 8 units, 401-450 =10 units. The Blood Glucose Monitoring Tool (referred to as Diabetic Flow Sheet) used for December indicated Resident #96's blood sugars were checked on the following dates and times but the insulin treatment for the blood sugars were blank: 12/2/11 at 6 A.M.=151 - 1 unit should have been administered 12/2/11 at 4 P.M.=352 - 8 units should have been administered 12/3/11 at 6 A.M.=185 - 2 units should have been administered 12/3/11 at 4 P.M.=310 - 7 units should have been administered 12/4/11 at 4 P.M.=332 - 7 units should have been administered 12/5/11 at 6 A.M.=147 - 1 unit should have been administered 12/5/11 at 4 P.M.=292 - 6 units should have been administered 12/6/11 at 4 P.M.=379 - 8 units should			

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	have been administered 12/7/11 at 4 P.M.=298 - 6 units should have been administered 12/8/11 at 6 A.M.=224 - 3 units should have been administered 12/8/11 at 4 P.M.= 315 - 7 units should have been administered 12/9/11 at 6 A.M.=220 - 3 units should have been administered 12/10/11 at 6 A.M.=194 - 2 units should have been administered On 1/27/12 at 12:30 P.M. during an interview with the DON, she indicated their facility did not have any other documentation of the units given for Resident #96. 3.1-35(g)(2)			

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F0309 SS=E	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on record review and interview, the facility failed to ensure residents were assessed and received treatment for absence of bowel movements in order to maintain optimal health in 4 of 14 residents reviewed for bowel movement assessment in a total sample of 24. Residents #29, #132, #50, #40. Findings include: 1. The clinical record for Resident #132 was reviewed on 1/24/12 at 11:00 a.m. The diagnoses for Resident #132 included, but were not limited to: obesity, dementia, Parkinsonism, and chronic back pain. The medical record also contained an 11/13/2011 assessment of a BIMS (brief interview for mental status) score of 13 out of 15 possible points, meaning that the resident was alert and oriented and able to understand questions and answer appropriately. Record review indicated a routine doctor's order for Polyethylene Glycol (Miralax) 3350 NF powder, mix 17 GM in 8 oz of liquid and give by mouth once daily.	F0309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Bowel assessments by a licensed nurse were immediately completed for residents #29, #132, #50 and #40 to ensure residents received treatment for absence of bowel movements, if any. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · BM records for all records were audited to identify any residents who had not had a bowel movement in 3 consecutive days. Any identified residents were provided a treatment as physician prescribed. · An audit was completed to ensure that residents with care plans for risk/actual constipation have physician prescribed treatments for the absence of bowel movements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	02/26/2012

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	Resident #132 did not have any medication prescribed as needed for constipation. Resident #132's December and January bowel movement records indicated Resident #132 did not have a BM from 12/25/11 through 01/09/12. Resident #132's December 2011 and January 2012 MAR (Medication Administration Record), indicated that no medication was given PRN (as needed) for constipation. In the Nurse's Notes, there was no indication that there was any abdominal assessments done and no MD (medical doctor) notification for no bowel movements between the dates of 12/25/2011 and 01/09/2012. A care plan for constipation indicated goal dates of 9/08/11, 11/30/2011, and 2/22/2012 for the intervention that an MD be notified if there is no BM for 3 days. Another intervention dated 05/26/12 indicated that MD should be notified prn (as needed) for laxative order or if interventions were ineffective. Another intervention on the care plan dated 05/26/2011 indicated administer laxative as ordered. Interview with Resident #132 on 1/26/2012 at 2:55 p.m. indicated that the		· The Director of Nursing Services and/or designee will assign a licensed nurse to review all resident BM records daily to identify any residents who have not had a bowel movement in 3 consecutive days. · Residents identified as not having a BM in 72 hours will have appropriate treatments initiated as physician prescribed to maintain healthy bowel elimination patterns. · An in-service will be completed by the Director of Nursing and/or designee on February 16, 2012 to nursing staff regarding facility policies to maintain healthy resident bowel elimination. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor facility compliance with resident bowel elimination procedures weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	resident did not recall having any long period of time between bowel movements and that if she had any problem of not going for more than two days she would have told someone (a nurse or an aide.) 2. The clinical record for Resident #50 was reviewed on 1/25/12 at 10:30 a.m. The diagnoses for Resident #50 included, but were not limited to: constipation, hypertension, right fibula/tibia fracture. The 12/17/12 Admission MDS (minimum data set) indicated: transfer - extensive assistance/2 person physical assist, ambulation (walk in room) - activity occurred only once or twice/ 1 person physical assist, hygiene - extensive assistance/1 person physical assist, toilet use - extensive assistance/1 person physical assist, bowel continence - always continent. The January, 2012 physician's recapitulation orders for Resident #50 indicated Miralax (a laxative) 17 grams mixed with 8 oz. of water p.o. (by mouth) before a.m. meal daily at 6:00 a.m. effective 12/13/11, Milk of Magnesia (a laxative) 30 ml once daily for constipation prn (as needed) effective 12/10/11, and Dulcolax (a suppository) 10 mg rectally daily at bedtime as needed for			

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	no bowel movements effective 12/14/11. The 12/5/11 constipation care plan indicated Resident #50 had a potential for constipation related to impaired mobility and pain meds (medications). The goal indicated on the care plan was for the resident to have a BM (bowel movement) at least q (every) 3 days. The approaches indicated on the care plan were to administer laxative as ordered, notify MD prn (as needed) for laxative order or if interventions ineffective, and to record BM's on the BM log. Review of the December 2011 Bowel and Bladder Detail Report indicated Resident #50 had a BM on 12/18/11, but did not have the next BM until 12/23/11. No information could be found in the clinical record to indicate any interventions including any PRN medications were given in this 5 day time period or that the MD was notified. Review of the January, 2012 Bowel and Bladder Detail Report indicated Resident #50 had a BM on 1/7/12, but did not have the next BM until 1/12/12. No information could be found in the clinical record to indicate any interventions including any PRN medications were given in this 5 day time period or that the MD was notified. During interview with Resident #50 on			

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	1/25/12 at 3:30 pm, she indicated she remembered being constipated during these time frames and that it was uncomfortable for her. She also indicated the staff never asked her if she needed a laxative. During interview with the DON on 1/26/12 at 10:55 a.m., she indicated she couldn't find any information to indicate any interventions were done or the MD was notified regarding these two 5 day periods of no bowel movements for Resident #50. The Bowel Elimination Policy provided by the DON on 1/26/12 at 10:30 a.m. stated, "7. A resident listing will be completed by the assigned charge nurse of resident(s) who have not had a bowel movement for 3 consecutive days. 8. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day. 9. Resident(s) not having result from the laxative or stool softener will be given an enema, if ordered by the physician. 10. If by the 4th afternoon, the resident(s) has not had results, the nurse will do an abdominal assessment, chart the results of the assessment, and notify the physician			

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	for further order." 3. The clinical record for Resident #29 was reviewed on 1/25/12 at 4:15 p.m. The diagnoses for Resident #29 included, but was not limited to: constipation, gastroesophageal reflux disease, and Alzheimer type dementia. A recapitulation of resident #29's October BM (bowel movement) records indicated that resident # 29 did not have a BM from 10/19/11 through 10/25/11. In a care plan for constipation, dated 9/12/11, one of the interventions indicated abdominal assessments should be done for bowel sounds, distention, pain, and tenderness. Another intervention on the care plan indicated the MD was to be notified if there was no BM for 3 days. A third intervention was to administer medication as ordered. A recapitulation of Resident #29's October 2011 MAR (Medication Administration Record), indicated no medication was given PRN (as needed) for constipation. There was an order for Milk of Magnesium (MOM) to be given PRN for constipation. A review of the MAR indicated that no MOM was given during the above time frame. In the			

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	Nurse's Notes, there was no indication there were any abdominal assessments done during the above time frame or a MD (medical doctor) notification was done for no BM for 3 days. In an interview with the DoN (Director of Nursing), on 1/27/12 at 12:15 p.m., she indicated she was unable to determine if there were any interventions done to promote a BM. 4. A record review on 1/24/12 at 3:30 P.M. of a Bowel and Bladder Report for Resident #40 indicated that a BM did not occur for 7 days from 12/6/11 to 12/13/11. On 12/6/11 at 5:30 P.M. nurse's notes indicated Resident #40 was straining to have a BM, physician was notified and a new order was received for 2 tabs of 8.5 mg of Senna to be given routinely at bedtime. No outcome of this medicine was shown and no further intervention was initiated until a stool was listed on the record dated 12/13/11. A nurse's note dated 12/9/11, indicated that an assessment was done, abdomen was soft and bowel sounds were active in 4 quadrants. During the dates of 12/13/11 to 12/18/11 (5 days) no stool was indicated, and from 12/18/11 to 12/27/11 (9 days) no bowel			

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	movements were noted in the record, and there were no interventions indicated. During an interview with the DON on 12/27/12 at 12:45 P.M., she provided a copy of an assessment done in nursing notes dated 12/24/11 indicating the abdomen of Resident #40 at that time was soft and non tender and there were bowel sounds in all 4 quadrants. 3.1-37(a)			

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F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident who entered the facility without pressure ulcers did not develop 3 pressure ulcers within 19 days of admission, for 1 of 5 residents reviewed for pressure ulcers in a total sample of 24. (Resident #47) Findings include: The clinical record for Resident #47 was reviewed on 1/26/12 at 10:30 a.m. and indicated the resident was admitted to the facility on 1/6/12. The diagnoses for Resident #47 included, but were not limited to: sepsis, hematuria, hyperglycemia, hypothyroidism, allergic rhinitis, diabetes mellitus type II, and depression. The 1/18/12 admission MDS (minimum data set) assessment for Resident #47 indicated: bed mobility - extensive assistance/one person physical assist, transfer - extensive assistance/one person	F0314	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #47 was immediately assessed and treated per physician order upon identification of the wound(s) and his risk for skin breakdown care plan was updated with new individualized interventions. Resident #47 no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Pressure wound risk assessments for all residents have been updated to reflect current accurate resident information. · Care plans for residents identified as high-risk for developing skin breakdown have been reviewed to ensure appropriate interventions are in place. · A facility-wide skin sweep has been completed to identify	02/26/2012

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	physical assist, walk in room - activity occurred only once or twice/one person physical assist, Is the resident at risk for developing pressure ulcers/yes, Does this resident have one or more unhealed pressure ulcer(s) at stage 1 or higher/no, BIMS (Brief Interview for Mental Status) score/15 (highest possible score indicating resident is cognitively intact). The 1/6/12 entry on the Interdisciplinary Progress Notes indicated "Skin assessment done (symbol for "no") areas noted... Skin very healthy looking." The 1/6/12 Nursing Admission Assessment indicated "Resident (symbol for "with") (symbol for "no") skin issues noted...". The 1/6/12 Pressure Wound Risk assessment indicated the resident was at risk for developing skin breakdown. Proceed to care plan with appropriate interventions. The 1/6/12 skin breakdown careplan indicated the resident was at risk for skin breakdown due to decreased mobility and incontinent of bowel. The goal indicated on the care plan was resident would be free from skin breakdown. The approaches indicated on the care plan were to turn and reposition at least every 2 hours and side rails in grab bar position to promote independence in bed.		residents with pressure areas and to ensure appropriate treatment and services to promote healing have been ordered. · Residents with orders for ¼ rails to help with bed mobility have been identified and beds checked to ensure ¼ rails are in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents who are new admissions/readmissions will have weekly pressure risk assessments completed by a licensed nurse for the first x 4 weeks. · Residents who are new admissions/readmissions will have a head to toe skin assessment completed within the first 24 hours of admission by a licensed nurse. · Licensed nurses will conduct rounds on residents with care plan interventions for turn and reposition to ensure interventions are occurring. Turn and reposition services will be documented on the resident MAR. · Rounds will be conducted weekly by the Rehab Services Manager and/or designee to ensure that siderails are in place as ordered. · Nursing staff will be in-serviced by Director of Nursing and/or designee on February 21,	

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	The 1/9/12 entry on the Interdisciplinary progress Notes indicated "IDT met to review resident for siderails. Determined 1/4 rails in grab bar position for assistance (symbol for "with") bed mobility..." The CNA Skin Check Detail Report indicated CNA #1 saw a new skin problem located on the buttocks area on 1/21/12. During interview with CNA #1 on 1/26/12 at 3:15 p.m., she indicated the area referenced above was bleeding when she noticed it on 1/21/12 and she told RN #1 right away. The 1/21/12 Skin Issue Investigation form for Resident #47 completed by RN #1 indicated the area on the coccyx was 0.6 cm x 0.3 cm x 0.1 cm with red granulation. Question #4 on this form asked "After interviewing staff, how would you conclude the injury happened (if not witnessed)?" The written answer was "The wound area on coccyx was a result of pressure area." The written recommendation to prevent recurrence on this form was "EPC cream (incontinent cream) relieving direct pressure from coccyx as much as possible." The 1/25/12 Wound Progress Note indicated 3 pressure wounds...a stage III		2012 on risk factors for skin breakdown and interventions to prevent pressure wound development. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with prevention interventions of residents at high-risk for developing pressure wounds by the Director of Nursing and/or designee. Resident observations will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	right buttock wound measuring 3.2 cm x 3.0 cm x 0.1 cm, an unstageable left buttock wound measuring 2.0 cm x 2.0 cm x 0.1 cm, and an unstageable sacrum wound measuring 0.7 cm x 0.5 cm x 0.1 cm. An observation of the wound area was made on 1/27/12 at 11:35 a.m. The affected area was the size of a fist with pink surrounding the wounds with areas of red spots. The actual wound size on the right buttock looked about the size of an index fingernail bed. The EPC cream was covering the pink area just above this wound disenabling full view of the entire wound. No siderails were affixed to Resident #47's bed during this observation. During interview with the DON on 1/27/12 at 1:35 p.m., she indicated there was no evidence to prove Resident #47 was turned and repositioned as care planned. An interview was conducted with Resident #47 on 1/27/12 at 2:00 p.m. He indicated staff never turned and repositioned him the first couple of weeks he resided at the facility. He stated, "I've never had siderails to help me turn myself. I wish I did. It would have been helpful. I'm sitting more now because it's			

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	more difficult to stand. There's pain on my bottom." During this interview, maintenance came in to install siderails at 2:10 p.m. on 1/27/12. The resident stated to maintenance "Oh, it's a little late coming." 3.1-40(a)(1)			

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F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview and record review, the facility failed to ensure chemicals and sharps were stored securely to prevent access by 25 of 32 residents on the secured dementia unit who were confused and mobile. (Residents #7, 8, 9, 10, 13, 14, 16, 18, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 32, 35, 36, 37, 33, 24, and 11) Findings included: An environmental tour of the facility was conducted on 1/27/12 at 10:25 a.m. with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor. The door to the linen closet on the Cottage Unit, secured dementia unit, was observed to be unlocked. A sign was posted on the door that read "Please keep this door locked at all times." Upon entrance of the unlocked door, a clear, opened bag was on the floor with 2 bottles of suntan lotion and 3 gardening tools (2 hand shovels and a hand fork) inside, clearly visible through the bag. During interview at this time with the Housekeeping/Laundry Supervisor, she indicated the door was supposed to be	F0323	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The 2 bottles of suntan lotion and 3 gardening tools were immediately secured behind a locked door. · All other doors within the facility were immediately checked to ensure there were no hazards within the environment for confused and mobile residents. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who are confused and mobile within the facility have been identified. Safety assessments of their environments have been conducted to ensure they are free of accident hazards. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be provided by the Memory Care Facilitator and/or designee on February 14, 2012 to all facility staff on identifying and securing hazardous items within resident	02/26/2012

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	locked. During interview with the Maintenance Supervisor at this time, he indicated the clear bag shouldn't have been in there. On 1/27/12 at 1:30 p.m., the DON provided a list of 25 ambulatory/self-propelled residents (Residents #7, 8, 9, 10, 13, 14, 16, 18, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 32, 35, 36, 37, 33, 24, and 11) on the Cottage Unit with severe or moderate cognitive impairment. 3.1-45(a)(1)		areas. · Facility rounds will be conducted daily by the Memory Care Facilitator and/or designee to ensure hazardous items are properly secured within areas that confused and mobile residents have access to. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Maintenance Director and/or designee to monitor compliance with properly securing hazardous items in areas in which confused and mobile residents have access to. Resident areas will be observed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.			
	Based on interview and record review, the facility failed to recognize and address a weight loss for potential concerns for 1 of 4 residents reviewed for weight in a total sample of 24. (Resident #50) Findings include: The clinical record for Resident #50 was reviewed on 1/25/12 at 10:30 a.m. The diagnoses for Resident #50 included, but were not limited to: closed bimalleolar fracture, constipation, hypertension, osteoporosis, hypothyroidism, and right fibula/tibia fracture. The 12/19/11 weight care plan for Resident #50 indicated the goal was for the resident to have no weight fluctuations of greater than 5% in 30 days and an approach was to monitor weight. The Weights Detail Report indicated Resident #50 weighed 167 lbs on 12/5/11	F0325	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · An interdisciplinary review was conducted for Resident #50 to address potential concerns for her identified weight loss. Resident's nutritional care plan was reviewed and updated to include individualized interventions. Resident's weight has stabilized at this time and she remains within her ideal body weight. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All resident weights were evaluated to ensure that any losses were identified/recognized. An interdisciplinary review was conducted for all residents with weight loss including the development of a nutritional care plan with individualized interventions. These residents will continue to be reviewed by	02/26/2012

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	and 158 lbs. on 12/14/11. It indicated the resident was weighed twice on 12/24/11 at 150 lbs and 149.8 lbs. respectively. No information could be found in the clinical record to indicate this 10.17% weight loss from 12/5/11 to 12/24/11, this 5.06% weight loss from 12/14/11 to 12/24/11, or this 5.3% weight loss from 12/5/11 to 12/14/11 was recognized and addressed for potential concerns. During interview with the Dietary Clinician on 1/26/12 at 11:15 a.m., she indicated it was no excuse, but she was off the week after 12/24/11 and that she expected nursing to have taken over for her and addressed this. She indicated the weight loss issue was not addressed until she spoke with Resident #50 on 1/6/12. 3.1-46(a)(1)		the interdisciplinary team to ensure interventions are effective and nutritional goals have been met. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Any residents who experience a 5% or more weight loss in 30 days will be reviewed by the interdisciplinary team for current nutritional status and implementation of individualized interventions. · Meal Managers will monitor a meal delivery daily for those residents experiencing weight loss to ensure compliance with receiving individualized nutritional interventions. · An in-service will be provided by the Registered Dietitian and/or designee on February 22, 2012 to the interdisciplinary team members regarding facility policy for reviewing residents with weight or nutritional concerns. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with facility policy for weight monitoring and IDT review of residents with weight and nutritional concerns weekly X 4	

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			weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure a pre and post assessment for administered prn (as needed) pain medication was utilized to monitor effectiveness and need, for 1 of 5 residents reviewed for prn pain medication administration in a sample of 24 (Resident #133). Findings include: The clinical record for Resident #133 was reviewed on 1/25/12 at 2:40 p.m. The diagnoses for Resident #133	F0329	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #133 was immediately assessed for pain and the efficacy of pain medication with no negative outcomes noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents receiving prn pain medication have been identified. Pain assessments will be completed for these residents to ensure their drug regimen does not include unnecessary drugs	02/26/2012

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	included, but were not limited to: osteoporosis, generalized arthritis, and degenerative joint disease. A recapitulation of the October and November 2011 MAR (Medication Administration Record) indicated there was an order for PRN (as needed) Hydrocodone/Acetaminophen 5/325, 2 tablets by mouth every 4 hours as needed for moderate to severe breakthrough pain. Hydrocodone 5/325 was given on 10/4/11 (no time indicated), 10/21/11 (no time indicated), and 11/10/11 (no time indicated.). There was no documentation to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given. A pain care plan indicated an approach, dated 4/4/11, was to observe effectiveness of PRN (as needed) medications. In an interview with the DoN (Director of Nursing), on 1/27/12 at 09:20 a.m., she indicated that she expects staff to document the effectiveness of prn pain medication. 3.1-48(a)(3) 3.1-48(a)(4)		and care plans updated to reflect current resident status/interventions. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents identified with prn pain medication orders will have pre and post assessments documented on MAR and/or nurses notes to include reasons for administration, interventions and effectiveness of administered pain medication. · An in-service will be completed by the Director of Nursing and/or designee on February 16, 2012 to licensed nurses on completing and documenting pre- and post-assessments for prn pain medication administration. · The Director of Nursing Services and/or designee will assign a licensed nurse to review the MAR's daily of all residents who receive a prn pain medication to ensure compliance with documentation of pre and post pain assessments. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance of pre and post assessments for prn pain medications. MAR and Nurses notes observations will be completed weekly X 4 weeks,	

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			monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	155757	A. BUILDING 00 B. WING	01/27/2012

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F0371 SS=D	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation and interview, the facility failed to ensure an employee used the appropriate utensils in a manner to prevent the potential spread of infection or decrease potential risk of contamination while serving a ready to eat food to Resident # 143. This deficient practice affected 1 of 17 residents who were assisted with eating meals in the Restorative Dining Room. Findings include: During a lunch observation on 1/26/12 at 11:30 A.M. CNA # 2 was observed in the Restorative Dining Room removing a muffin from a wrapper with bare hands and placing it on the dish of Resident # 143. During an interview on 1/26/12 at 1:00 P.M. with CNA # 2, she acknowledged that she touched the muffin with her bare hands. She indicated she had been trained not to touch food with bare hands on ready to eat foods, but it had been a long time since that inservicing. 3.1-21(i)(3)	F0371	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Immediate education was provided to C.N.A. #2 about using appropriate utensils to serve ready to eat foods to residents. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who require assistance with ready to eat foods have been identified. · Nursing staff that assist residents with eating have been in-serviced on the proper method for serving ready to eat foods so as to prevent contamination and possible spread of infection. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be conducted by the Dietary Services Manager and/or designee on February 23, 2012 to facility staff that serve food to residents and/or assist residents with eating. The in-service will train on the proper method for	02/26/2012

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			serving ready to eat foods so as to prevent contamination and possible spread of infection. · Meal observations will be conducted by the Dietary Services Manager and/or designee every other day to monitor for food being served under sanitary conditions. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Infection Control Coordinator and/or designee to monitor compliance with utilizing appropriate utensils to serve ready to eat foods to residents. Meal service will be observed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0372 SS=F	The facility must dispose of garbage and refuse properly. Based on observation and interview, the facility failed to properly contain refuse in dumpsters with closed side doors. This had the potential to affect 145 of 145 residents in the facility. Findings include: An environmental tour of the facility was conducted on 1/27/12 at 10:25 a.m. with the Maintenance Supervisor. At 11:10 a.m. on 1/27/12, during the environmental tour, there was an observation of a facility dumpster that had 3 bags of garbage on the ground next to the dumpster with refuse in each of them. The side doors were opened on both sides of the dumpster with refuse in the dumpster. During interview with the Maintenance Supervisor on 1/27/12 at 11:10 a.m., he indicated the doors on the sides of the dumpster should have been closed and the garbage bags should not have been on the ground. He also indicated his staff usually checked the garbage every morning to ensure it was contained. During an observation on 1/27/12 at 1:50 p.m., the same facility dumpster had 2 bags of garbage on the ground next to the dumpster with refuse in each of them and	F0372	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The 3 bags of garbage on the ground next to the dumpster were placed in the dumpster. · The Maintenance Director was educated about immediately disposing of garbage that is not properly contained in the dumpster and closing dumpster doors when observed open. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Executive Director has contacted facility trash vendor to explore alternative options for properly containing garbage/refuse. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be conducted by the Maintenance Director and/or designee on February 14, 2012 to all facility staff about proper disposal of garbage along with maintaining dumpster door closure.	02/26/2012

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	1 side door was opened with refuse in the dumpster. During interview with the Maintenance Supervisor on 1/27/12 at 1:50 p.m., he indicated one of his staff was supposed to take care of the garbage after the first observation at 11:10 a.m. on 1/27/12. 3.1-21(i)(5)		· Observations of the dumpster area will be conducted by the Maintenance Director and/or designee daily to ensure garbage is properly disposed of and dumpster doors remain closed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Infection Control Coordinator and/or designee to monitor compliance with proper disposal and containment of garbage/refuse. The dumpster area will be observed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on record review and interview, the facility failed to complete clinical records containing an accurate representation of the actual experience of an individual in a facility. This was evidenced for 1 resident (Resident C) of 24 residents whose records were reviewed, in a sample of 24. Findings include: Review of Resident #C's record on 1/24/12 at 3:10 P.M. indicated the following: Documentation was observed as being incomplete for oral care on every shift, ordered by recap of physician's order dated 1/1/12 (due to resident being NPO). Oral care was not documented on 1/7, 12, 13 for 1st shift (10:00 P.M. to 6:00 A.M.) , 1/14, 15, 18, 19 for 2nd shift (6:00 A.M. to 2:00 P.M.) and on 1/23 on 3rd shift (2:00 P.M. to 10:00 P.M.).	F0514	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident C was immediately assessed for appropriate oral health as well as trach maintenance with no negative outcomes noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with physician ordered oral care due to being NPO were identified and assessed for appropriate oral health. · There are no other residents who require trach care services at this time. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents requiring physician ordered oral care due	02/26/2012

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	During a review of a Trach Care record for Resident #C, documentation was observed as being incomplete for care on every shift, ordered by recap of physician's order dated 1/1/12 for Hydrogen Perox 3% solution for trach care every shift. This care was not documented as having been done on 1/3, 7, 12, 13, 21 for 1st shift (10:00 P.M. to 6:00 A.M.), 1/14, 15, 18, 19 for 2nd shift (6:00 A.M. to 2:00 P.M.) and on 1/23 for 3rd shift (2:00 P.M. to 10:00 P.M.). On 1/24/12 at 3:35 P.M. during an interview with LPN # 1, reviewing Resident #C's record, she indicated that she had not worked on this unit previously to explain why it wasn't documented appropriately, but that she was taught if it wasn't documented it wasn't done, but that it was probably just not documented.		to being NPO will have oral care services provided and documented on the resident MAR (medication administration record). · Residents requiring trach care will have services provided and documented on the resident MAR. · An in-service will be completed by the Director of Nursing and/or designee on February 21, 2012 to licensed nurses on documentation requirements of services provided. · The Director of Nursing Services and/or designee will assign a licensed nurse to review the medication and treatment administration records daily of all residents who require oral care due to being NPO as well as those requiring trach care. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance of documented oral and trach care services weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified	

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	3.1-50(a)(2)		noncompliance may result in staff re-education and/or disciplinary action.	

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F9999				
	STATE FINDING: 3.1-14 Personnel 1. A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two step	F9999	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Employees #1 and #2 were unidentified. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · An audit of all active employee files has been completed to ensure that records include a documented negative tuberculin skin test result within the preceding twelve months or prior to the employee working. For those employees identified who do not have a documented negative tuberculosis skin test result as outlined above, a tuberculin skin test will be administered test as prescribed by state rule. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be conducted by the Director of Nursing and/or designee on February 22, 2012 to the Infection Control Coordinator and Payroll Coordinator regarding the required screening for health care workers.	02/26/2012

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	method. If the 1st step is negative, a 2nd test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat will depend on the risk of infection with tuberculosis. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to appropriately screen employees for tuberculosis. This impacted 2 of 10 employees whose files were reviewed. (Employees #1 and #2) Findings include: The Administrator provided a completed State Form 5440 for all current employees on 1/27/12 at 12:00 P.M. The file of employee #1 was reviewed on 1/27/12 at 12:45 P.M. and indicated the 1st step had been completed at the time of employment on 11/11/11 but the 2nd step was not marked. The file of employee #2 was reviewed on 1/27/12 at 1:00 P.M. and indicated the 1st step was completed at the time of employment on 10/20/11 but the 2nd step was not marked. During an interview with the		· New hire processes will be developed by the Executive Director to ensure that all screening requirements have been met prior to an employee beginning work. · A tickler file system will be developed by the Executive Director to track annual due dates for current employees to ensure tuberculin skin tests are administered on an on-going basis. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Executive Director and/or designee to monitor compliance with appropriate employee screenings for tuberculosis. New hire personnel file audits will be conducted prior to all new employees working for 90 days. An audit of the current employee tuberculin skin test tickler file system will be conducted weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.	

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	Administrator on 1/27/12 at 4:00 P.M. she indicated the facility had no further information regarding the TB testing of employees #1 and 2. 3.1-14(t)			